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NATIONAL HOSPITAL
PROSPECTIVE PAYMENT EVALUATION

CASE STUDY SITE REPORT:

NORTHWEST VERMONT

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PREFACE

This is one of ten site reports of case studies conducted between September and December, 1986, by staff members of Abt Associates, Inc. and Health Economics Research, Inc. under Contract No. 500-85-0015 to the Health Care Financing Administration (HCFA). The views expressed are our own and no endorsement by HCFA or the Department of Health and Human Services is intended or should be inferred. Each report is a summary of the facts and subjective comments from all participants at one of the ten sites.

This report characterizes the structures of parts of the health care industry (e.g., hospitals, nursing homes, home health agencies) in this site as they were perceived by members of the study team. Individual respondents and institutions are not mentioned by name, nor are they meant to be identifiable. We are interested in generalizing about the responses of the industry to the Medicare prospective payment system, not in pointing out any one type of response. We would like to raise the appropriate policy issues objectively and from all points of view. These issues can then be addressed in the statistical analyses of data on beneficiaries and providers, which in turn will be synthesized by HCFA staff into the Congressionally-mandated report about the impacts of the prospective payment system.

The ten site reports will not make up the report to Congress. The ten sites are not a scientifically representative sample of the nation's health care providers. Therefore, they are only illustrative of what is happening across the country. As such, they have already proven to be invaluable to the study staffs. The information and subjective opinions of the 500-600 respondents will be incorporated in the analyses of secondary data in five topic areas: hospital competition, alternative health plans, medical practice patterns, post-hospital care, and program operations. They are being used in developing hypotheses, exploring unexpected results and raising policy concerns.

We once again thank those many respondents who so generously gave us their time for the discussions that provided these insights. Special thanks are also due to the support staffs of Health Economics Research and Abt Associates for arranging the site visits and producing the reports, and to the secretaries of participating executives who coordinated the interviewing schedules in the field.

1.0 OVERVIEW OF NORTHWESTERN VERMONT

The Northwestern Vermont site includes five counties: Chittenden, Grand Isle, LaMoille, Washington, and Addison. The small Burlington MSA is Chittenden County, bordering on Lake Champlain, which forms a natural market barrier between upstate Vermont and New York. The five counties range in size from 117,800 in Chittenden to only 16,900 in mountainous LaMoille (where the Stowe ski resort is located). The population is only 2-3 percent non-white with almost no urban poverty. The Green Mountains form another natural barrier between the cities and towns along the New York border on the west and Montpelier, the state capitol, and Morrisville, in La Moille County in central Vermont. Historically, this ridge of mountains presented significant travel difficulties between the mountainous central and western valley towns, but Highway 89 now makes commuting between Montpelier and Burlington within 40 minutes feasible--in all but the worst weather.

There are six hospitals in northwestern Vermont, one each in the rural counties, plus two in the Burlington MSA. Except for the last two, all are at least 25 miles from the nearest hospital, qualifying for sole community hospital (SCH) status. One hospital, however, opted out of SCH status after the first year of PPS.

Competition among the region's hospitals is naturally limited by terrain and distance, with the exception of the two urban institutions. Inpatient use is down considerably, nonetheless, in all but the tertiary care center, which appears to be attracting patients away from smaller hospitals. Profits fell dramatically for several rural facilities under the first year of Medicare prospective payment, but nearly all have cut costs and developed new revenue sources to improve viability. The smaller urban hospital, while facing more immediate competition from the dominant medical center, is still doing well financially, attributable in large part to the higher Federal urban rate it enjoys relative to its costs.

Hospitals have taken numerous steps to control costs including eliminating and converting beds to outpatient care, laying off employees, monitoring nursing productivity, computerizing many management functions, and performing special DRG efficiency studies.

Price competition is limited primarily to the emergency room and ancillaries, as hospitals compete with physicians and independent laboratories for patients and outpatient diagnostic testing.

Non-price rivalry is far more important. Both urban and rural hospitals are diversifying rapidly into ambulatory care, e.g., home respiratory care and sports medicine. Rural hospitals, in addition, are recruiting specialists to stem the flow of patients into Burlington. They are also setting up physicians in surrounding communities to assure referrals to their institutions. Nearly all are actively promoting their facilities, although generally not through television or radio. Local newsletters and guest relations programs are a more common approach. One hospital is even offering "guaranteed" care with waiver of the bill if the patient is unsatisfied.

Hospitals have begun discharging patients sooner, but this has not been accomplished by extraordinary pressure on physicians. Hospital administrators have upgraded discharge planning, and taking advantage of an expanding home health industry. They have also been using subacute units in the hospital or building nursing homes.

Nursing home beds are in short supply in this region, putting added pressure on the home health industry to provide more high-tech care. Medicare SNF patients are not attractive to nursing homes in any event because they are sicker, particularly now that they are being discharged sooner, and occupancy rates are already near 100 percent. Hospitals are therefore quite interested in building new homes although state certification laws restrict growth.

Nearly all interviewees agree that social admissions are down considerably, but hospitals are still accepting a few either gratis or informing the patient beforehand that they will be billed directly. Lack of social support and poverty among Vermont's rural population are frequently cited by discharge planners and home health nurses as problems exacerbated by earlier discharges and PRO denials. Financial, rather than medical, concerns are mentioned much more often, however, as providers feel patients generally would get outpatient care if they could pay for it.

2.0 SCOPE OF INTERVIEWS

The Burlington area site visit was conducted with a series of interviews both inside and outside hospitals. Two urban and four rural hospitals in the northwestern Vermont area participated in the study. Three of the four rural hospitals are classified as sole community hospitals. Four of the six hospitals have bedsizes of about 100 beds or smaller, one has about 150 acute beds, and the large teaching hospital has 500 beds.

A total of 48 people were interviewed over a five day period (See Table 1). Six chief executive officers, four chief financial officers, two controllers, and one vice president of operations were questioned in the area of competition. Six discharge planners were questioned about aftercare industry. The areas of inpatient utilization and patient management were discussed with three medical directors, three chiefs of staff and five U/R coordinators. Outside the hospital, three additional physicians were interviewed for the utilization/patient management area. All three were cardiologists and were admitting physicians in at least one of the six hospitals.

Interviews covering the program operations area were conducted at the Fiscal Intermediary (FI) and two Peer Review Organizations (PROs) the local Vermont PSRO and the New Hampshire PRO, which has subcontracted with the Vermont PSRO for Vermont UR. One day was spent in New Hampshire interviewing the director of the PRO and the Director of Data and Finance. The director of the Vermont PSRO was also interviewed. Blue Cross of New Hampshire is the Medicare FI for both Vermont and New Hampshire. Another day was spent interviewing the Director of Government Programs, the Director of Utilization and Medical Review, and the Administrative Assistant to the Director of Government Programs.

Interviews were conducted with the aftercare industry both inside and outside the hospitals. In addition to the six discharge planner interviews in the hospitals, a Vermont Assembly of Home Health Agencies was attended and eight outside interviews were conducted with three nursing home administrators, four home health agency administrators, and a member of the Vermont Nursing Association.

TABLE 1

BURLINGTON, VERMONT SITE VISIT INTERVIEWS BY TOPIC AREA

	Competition	Utilization and Patient Management	Aftercare Industry	Program Operations
CEOs	6			
CFOs	4			
Controllers	2			
V.P. of Operations	1			
U/R Coordinator		5		
Medical Director		3		
Chief of Staff		3		
Cardiologists		3		
Discharge Planners			6	
Director of New Hampshire PRO				1
Director of Vermont PSRO				1
Fiscal Intermediary				4
Nursing Home Administrators			3	
Home Health Agency Administrators			4	
Member of Vermont Nursing Association			1	
Executive Director Area Assoc. of Aging			1	
Total Number of Interviews	13	14	15	6

3.0 HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS

3.1 Competitive Market Structure

The degree of potential competition in northwestern Vermont is severely limited by the geographic dispersion of the six hospital providers. Only the two urban hospitals are within 25 miles of each other. The hilly terrain down the spine of the state also isolates the two central Vermont hospitals somewhat from each other and the other western hospitals. Good, flat, roads connect the two rural hospitals to Burlington, however, tying them more to the urban center. Thus, the four rural hospitals are each distant enough from each other to preserve a reasonable population base, at least for community services. Nevertheless, a significant number of patient transfers (possibly 15-25 percent) to the MSA present volume problems when exogenous shocks, like PPS, are introduced.

The dispersion of hospitals notwithstanding, the whole region is dominated by the major urban teaching hospital. It has 500 acute care beds, making it 4-10 times larger than the other five institutions. It has a large teaching program and nearly 200 affiliated physicians. The other five hospitals range from roughly 50 to 150 acute care beds, with two having sizable nursing homes as well. The Medical Center is a leader for the entire state in facilities and services, room charges, and wages. Because of the notable asymmetry in size and scope of services, the Medical Center receives transfers from all over the state and even exchanges patients with the equally large teaching hospital in Hanover, New Hampshire. Were the Medical Center to disappear tomorrow, the competitive environment in northwestern Vermont would change radically, alleviating admissions pressures on surrounding urban and rural hospitals.

All six hospitals are non-profit, and one is also Catholic-affiliated, a fact with some competitive implications discussed later.

Insurance coverage for inpatient care varies across the six hospitals, with Medicare averaging between 40-50 percent; Blue Cross, 20-25 percent; commercial-self pay, 20-25 percent; and Medicaid, 4-9 percent. Bad debts are about 3-6 percent. The Medical Center has a somewhat lower Medicare share because of the higher percentage of younger, tertiary-care, patients it treats. To date, there are no HMOs, PPOs, or IPAs in the entire five county area, although a very small one is trying to start in Burlington with little success. Blue Cross pays charges throughout the state with only a 4 percent discount rate. Thus, with Medicare switching to charges, all third parties in the State now pay charges with little discounting.

Four of the six hospitals in the identified counties are paid Medicare's rural rate. Three of the four have SCH status as well, which weights their own standardized costs by 75 percent. While this affords considerable protection against the national rural rate among SCHs nationwide, northwestern Vermont hospitals are not particularly costly anyway, and their hospital-specific portions (HSPs) and Federal portions

(FPs) are not significantly different. The hospital that is a notable exception in having much lower hospital-specific costs rejected SCH status in the second year of the program.

The two urban hospitals, while both receiving the same urban rate and wage adjustment, have radically different standardized costs. The Medical Center's own costs run several hundred dollars above the Federal rate while the small urban's HSP is roughly the same amount below, resulting in a large shelter or windfall to the smaller institution. No hospital, including the Medical Center, receives a large percentage of its Medicare revenues from outliers (2-5 percent), but the Medical Center received nearly an 11 percent add-on for indirect medical education (IME) in 1985. The Medical Center also had the largest rise in its Medicare casemix index (CMI), going from 1.2 to 1.5, a 25 percent increase. Three other hospitals have had CMI increases somewhat less than half as large while two actually have had slight declines--possibly due to recalibration on charges. Thus, ignoring changes in actual costs and revenues due to volume changes or management improvements, several of the small SCH hospitals have increased their Medicare revenues through improved coding and trivial outlier supplements, while another has received the advantage of higher Federal rates by opting out of SCH status. The two urban hospitals have added significantly to their historical Medicare revenues, ceteris paribus, either by being well below the urban rate to begin with or through large IME payments and improved casemix coding.

A final factor in the competitive structure of the system is the presence of the Vermont Data Council, a non-binding rate-setting body that collects price, cost, and volume data from all hospitals each year and negotiates allowable charge increases. In theory, hospitals showing significant profits are held to flat or reduced rates in subsequent years, but decisions are non-binding. All hospital executives feel that public scrutiny has constrained the rate of price increases, but all also attribute their financial success since PPS began to the generosity of Blue Cross.

3.2 Hospital Performance

All hospitals except the tertiary Medical Center have experienced substantial reductions in admissions and patient days. Patient days are 15-25 percent lower in the four rural hospitals with occupancy rates running 60-65 percent. (Rates would have been much lower in a couple of hospitals if it were not for bed conversions.) The two urban hospitals are doing relatively better. The small urban hospital has admissions and days declines of only about 8-10 percent while the Medical Center has far exceeded its volume projections. It would appear that some of the decline in rural utilization has been the result of greater patient migration to Burlington although this probably explains only a minor part of the rural decline. Growing outpatient surgery and denial of social, or unnecessary, admissions appear more important.

In spite of significant volume declines almost everywhere, only one hospital was losing money in 1986--at least on a total margin basis.

Profit rates showed a definite pattern, though, with large losses or small profits in the first year of PPS forcing most hospitals to make major cost cutting decisions (as described in the next section). Once these changes took hold, charges were raised to other payers, and a couple of hospitals began to enjoy the benefit of a higher Federal rate, profitability turned completely around. Because the Medical Center exceeded its volume projections, supplemented by large IME and higher casemix payments, its financial status was never uncertain.

While no hospital appears to be in serious financial trouble today, one has a small loss projected due to unusual costs resulting from the loss of two doctors who admitted a large number of patients. A couple may also have trouble in the future depending on HCFA's capital payment policies, any increases in the Blue Cross discount, or any difficulties in maintaining specialists. Were HCFA to make a major change in SCH policy or narrow the urban-rural difference, a couple of hospitals reportedly could have serious financial problems, albeit not insurmountable.

3.3 Competitive Processes

Hospitals compete in three ways. The first is through lower prices, or at least slower rates of increase, that attract patients. The second is through management improvements that lower costs for a fixed price schedule. Third, hospitals can engage in various forms of non-price competition.

3.3.1 Price Competition

As expected, the usual price competition observed in most other industries is circumscribed in the northwestern Vermont area. While lower emergency room rates are being used to attract new admissions in a couple of hospitals, the practice is not widespread (See Table 2). Room rate competition is acknowledged by several administrators, but it is not construed to be the first line of defense against lower volumes. Because Blue Cross pays charges with only a trivial discount, most hospitals are reluctant to lower rates. Indeed, most hospitals have raised charges to make up for unexpected volume declines, expecting little further volume reductions. Even profitable hospitals have continued to raise prices marginally in spite of requests from the rate-setting authority to roll back prices and return profits to consumers.

Some evidence of price competition exists, nevertheless. Besides some price competition in the ER, one hospital has lowered lab charges in a successful attempt to capture volume from a local laboratory. Declining admissions have left several ancillary departments grossly underutilized, encouraging hospitals to "contract out" some of their lab, x-ray, and pharmacy services to local physicians. Almost zero marginal costs for many of these tests allows underutilized hospitals to compete successfully in such markets, partially offsetting losses from inpatients.

Because consumers pay little of their hospital bill, demand is quite price insensitive. Thus, industry price leaders do not exist per

TABLE 2

NEW COMPETITIVE STRATEGIES IN NORTHWESTERN VERMONT

PRICE COMPETITION	COST COMPETITION	NON-PRICE COMPETITION
Lower Emergency Room Rates	**Structural** • Bed conversions to nursing, rehab, and psychiatric beds • Bed conversion to support services and offices	**Services** • 24 hour ER • Birthing center • Satellite Physical Therapy Clinic • Home respiratory service
Lower lab/xray Charges	• Less intensive nursing units	• Sports medicine clinic
Lower daily room Charges	• Outpatient surgery • Ambulatory Testing	• Rehab unit • Radiation therapy • DME,EKG outpatient services
	Labor Costs • Lay-offs • Frozen wages • Nursing productivity systems • Variable staffing • Performance Contracting	• Referral lab/xray/ pharmacy • Centers of Excellence • Magnetic Resonance Imaging
	Non-Labor Costs • Generics in pharmacy • Computerization of ordering • Computerized medical record • Group planning	**Specialists** • Cardiologists, general surgeons, ophthalmologists, urologists, orthopods
	Utilization Controls • DRG-Specific special studies of length of stay, supplies	**Primary Care Network** • Capitalizing local office practices
	Organizational • Avoiding weekend elective surgery • Consolidating management	**Promotion** • Guest relations • Guaranteed care • Satisfaction surveys • Patient Education Center • Newspaper, radio advertising • Community newsletters

se. Rather, the large urban Medical Center generally has the highest charges for most routine and ancillary services and other hospitals "justify" their rates to third parties in relation to this hospital. Higher rates in tertiary hospitals often act as a ceiling on rates charged by less sophisticated hospitals via formal or informal review by Blue Cross (if it pays charges, as in Vermont) or a state rate-setting commission (i.e., the Data Council). Were the Medical Center to engage in significant price rollbacks for whatever reason, other hospitals would be hard-pressed to justify increases to either Blue Cross or the Data Council, except as a pure protection of fixed costs against declining volumes.

3.3.2 Cost Competition

Downward price rigidity due to charge-based Blue Cross and the high-price leadership of the tertiary care center in Burlington results in a greater emphasis on cost and non-price competition. Cost management efforts can be categorized into five areas (See Table 2):

(1) Structural;

(2) Labor Costs;

(3) Non-labor Costs;

(4) Utilization Controls; and

(5) Organizational.

Hospitals are undertaking several structural changes to more effectively use expensive beds and facilities. These include conversions of beds and space to swing beds, to less intensive acute nursing units, to more room for more outpatient surgery and testing and support services like speech and physical therapy, and even for administrative offices. One hospital is setting up an Ambulatory Testing Center to do more pre-admission work-ups in a less costly environment. Finally, all hospitals, urban-rural, small-large, have seen the amount of same day, or ambulatory, surgery expand to the point where nearly half of all surgery is being done without an overnight admission. This is a major structural change, requiring conversion of inpatient beds and space to outpatient waiting and recovery rooms.

Hospitals are addressing labor costs in the first instance through lower wage increases and productivity gains, followed by labor attrition and, as a last resort, lay-offs where drastic volume declines cannot be accommodated otherwise. Generally, wages have been frozen or increased at rates consistent with the low inflation generally in the post-PPS environment. The Data Council reportedly expects the Medical Center again to play a leadership role by approving very nominal wage increases, signaling other providers to hold the line (as well as reducing

competitive pressures to raise wages). Labor productivity gains are being achieved through variable staffing of the OR, block OR scheduling by specialty, introducing patient classification systems to better evaluate nursing requirements, and eliminating marginal nurses' aides. All hospitals seem committed to team nursing and the delegation of less-skilled tasks to LPNs although the RN/LPN ratio is rising due to the increasing severity of admitted patients.

Hospitals in response to PPS incentives are also undertaking numerous ways of reducing non-labor costs: introducing generics and a standardized formulary in the pharmacy; extensive computerization of internal ordering of tests, drugs, and supplies; even computerizing the bedside medical record in two institutions, one large, one small. Three hospitals have joined the Voluntary Hospitals of America to save through group purchasing and all three see this as a competitive advantage over non-participants.

All hospitals, to varying degrees, are using computerized DRG reports to target utilization evaluations to reduce costs per admission. In some cases they uncover sources of inefficiency that can be addressed through a new piece of equipment (e.g., a C-arm in surgery) or a cheaper prosthesis is discovered. More often, though, these evaluations identify aberrant physicians, who are encouraged to reduce lengths of stay.

Finally, almost all of the six hospitals have undergone a financial and administrative reorganization in the last 3-4 years. Hospitals in northwestern Vermont are vertically integrating with nursing homes (several already were affiliated with a home before PPS began) and some administrators are thinking of starting a hospital-based home health agency. In the majority of cases, the hospitals are now technically part of larger holding companies that act as fund raisers and supply management services to the hospitals and the other corporate entities. This reorganization can reduce overhead administrative costs in managing the hospital along with a nursing home or other subsidiary. More importantly, though, it "shelters the assets" of nonprofit hospitals from third party regulations and tax laws regarding excess profits. For example, if a hospital generates extra revenue by providing lab services to local physicians, any profits would be "taxed away" through lower allowed charge increases by the Vermont Data Council.* If a separate, for-profit entity is established, with profits flowing not directly to the hospital but indirectly through the holding company, the hospital's lab assets, and the profits they generate, are protected from charge rollbacks.

3.3.3 Non-Price Competition

Non-price competition is particularly virulent among the six northwestern Vermont hospitals. It takes four forms. First, and most obvious, are services. A couple of hospitals are providing referral lab,

*HCFA's downward adjustment in the update factor, which is partially justified on an "excess profits" argument, is another reason for sheltering profits from other activities.

x-ray, and pharmacy services to local physicians. Also included are birthing centers, satellite physical therapy clinics, home respiratory services, and even a sports medicine clinic. Several hospitals have introduced 24-hour emergency rooms to build community ties. The Medical Center is also developing a "hub-and-spoke" agreement with two rural hospitals to provide them with technical and medical support for rehabilitation and radiation therapy units. The quid pro quo is a formal understanding to maintain referrals to the Medical Center rather than switch to the other large teaching hospital in Hanover, New Hampshire. Furthermore, as the leader in providing a full range of tertiary services, the Medical Center is applying for a CON to purchase a $3.5 million Magnetic Resonance Imaging unit. This is part of its Centers of Excellence strategy to maintain its pre-eminent reputation in the state.

The second, and most important, way rural hospitals are competing is through the recruitment of specialists. Cardiologists and orthopedic surgeons are in particular demand, but hospitals have just recruited (or are actively seeking) ophthalmologists, obstetricians, urologists, and general surgeons as well. On-site specialists accomplish two goals. First, they arrest the flow of referrals to the Medical Center, stabilizing volumes. Second, they add materially to the hospital's image in the community, increasing the likelihood that other patients will use the local hospital.

Specialists are not perceived to be difficult to recruit, except in one instance which may have had more to do with the hospital's uncertain future. All directors attribute this to the growing oversupply of specialists and the attractiveness of northwestern Vermont.

Hospitals do not appear to be actively developing primary care networks with the notable exception of a hospital that is using some of its recent profits to capitalize primary care physicians in three neighboring communities. By assuring referrals from these physicians, this hospital is clearly setting up barriers against encroachments from other rural and urban hospitals. The logic of this strategy naturally depends on the extent of hospital competition: generally the more proximate are other hospitals, the more valuable is such a primary care network. It also depends on the internal funds in the institution, not to mention the aggressiveness of management. Poorer rural hospitals may not be able to undertake such networking, creating an even more uncertain future. However, four rural hospitals appear to be on the verge of networking with each other. It is also noteworthy that some of the PPS-generated profits are being plowed back into primary care in the local community.

Promotion is the fourth area of non-price competition. Several hospitals either had or were considering a guest relations program with outside contractors holding in-hospital seminars to sensitize staff to the needs of patients. One hospital had introduced a satisfaction survey that is sent to each patient a week after discharge. Positive comments are distributed to hospital staff while negative comments are answered to in writing and communicated directly to the department heads. The Patient Affairs subcommittee of the hospital board also reviews every negative comment. Another hospital is considering a guaranteed care

policy. If the patient is unsatisfied with his/her care, no payment is required. One hospital has even gone so far as to produce a hospital bill that is more comprehensible to patients.

Yet another hospital has established a Patient Education Center. Center staff go out into the community, into offices, schools, and the like, teaching health promotion and illness prevention. Besides improving health status, the program promotes the hospital's name and raises community awareness of the hospital and its services.

Several other hospitals are using the media to get their messages to the public. In the past this has amounted to working with local newspapers on favorable reports on activities of the hospital. Now promotion is more aggressive. One hospital places promotional ads in local newspapers and the radio (but not television--as yet). The hospital also sends monthly hospital reports to all residents in the county describing new services, new specialists, changes in rates, etc.

3.4 DRG Monitoring

All six participating hospitals have purchased or developed their own computer software to monitor hospital and physician performance by DRG. A typical report gives the following by DRG, with DRGs grouped by service, e.g., cardiology:

- Number of cases (possibly current vs. previous year)
- Average total charges per admission
- Average Medicare DRG reimbursement
- Average gain or loss per admission by DRG
- Average geometric LOS per actual admission
- Average geometric Medicare LOS.

Hospital CEOs and CFOs (among others) reviewed such reports intensively during the first two years of PPS, but less attention is paid to them now (for reasons discussed below).

What do administrators do with these reports? First, in nearly all hospitals they are used to identify "problem," or "losing," DRGs. In one hospital all DRGs with aggregate losses over $50,000 are singled out for special study while other hospitals look both at total losses and unusual aberrations. In almost every hospital, this has led to special studies of utilization patterns and supply purchasing. Lens procedures (DRG39) are most frequently mentioned, in part due to the PRO's requirement that it be done on an outpatient basis if at all possible. Other special studies include deliveries, open heart surgery, hip surgery, and pneumonia, but the list routinely includes many of the high volume DRGs. A few hospitals have used Travenol's Value Improvement Program for systematic review of costly therapies (e.g., catheterization), resulting in more outpatient treatment.

Usually, the task of reviewing individual cases is delegated to a small committee including the UR coordinator (usually a nurse) and one or more physicians specializing in the DRG. A typical finding is that new equipment can be purchased to allow the procedure to be done on an outpatient basis (e.g., lens procedures), or that a cheaper prosthesis or lens is available at comparable quality. Special studies also reveal that a source of higher charges for orthopedic surgery can be the lack of a C-arm in the operating suite, adding significantly to OR time and charges. Recognizing this, hospital administrators are searching for ways to buy this equipment to improve productivity.

The second use of these reports is to change the practice patterns of physicians, which happens in a variety of ways. At the most general level, the hospital's CEO makes a presentation of PPS at a monthly all-staff meeting. This always includes an overview of the obvious LOS, ancillary use, and admissions incentives--possible with slides and charts. Rarely, a CEO will attend grand rounds to learn about the hospital's patient mix and treatment patterns and bottlenecks. At the beginning of PPS, one CEO at monthly medical staff meetings reported PRO denial rates by DRG, results of special DRG studies, and how the hospital was doing financially, but this appears unusual. Rather, physicians are reminded of the professional and financial stake they have in their hospital and how the hospital could afford their equipment requests if costs go down.

CEOs tend not to dwell on profits and losses. This may be because, in the words of one CEO, it is "not my job to whip physicians for HCFA," but more likely reasons include (a) only a limited squeeze on profits, and/or (b) more indirect approaches to dealing with physicians. In large staff meetings, the CEO usually tells physicians that it is their job to manage patients, not his or hers, and that they should continue to do so in as resource-conservative a manner as feasible. The last thing a CEO wants is a "horror story" that could permanently damage the hospital's reputation-- particularly in rural hospitals already triaging patients to the Medical Center. Far better, it seems, to delegate review responsiblity to those better able to deal with the terminology and necessities of medical practice, namely, physicians and nurses.

Practically all of the DRG reports break out charges and patients by individual physician. These reports are used in small groups to talk with aberrant physicians. Each physician may also receive a confidential winners- and-losers report comparing them to the average practitioner for that DRG. The already conservative "Yankee medical ethic" in this state has not produced widespread overutilization. Usually, these DRG studies identify an atypical practitioner in terms of LOS across several DRGs.

Numerous problems with the DRG software also appear to nullify the value of DRGs as a tool for changing practice patterns in many instances. For example, most reports the CEO and CFO see compare actual hospital charges to Medicare PPS payments to identify winners and losers. Charges not only do not reflect average costs, a fact recognized by several CFOs, but are particularly bad at measuring marginal costs. Ancillary-intensive DRGs may appear to be losers on a charge-to-Medicare payment basis when they are more than covering real direct costs, not to

mention overhead. CFOs sense this problem but do not have the accounting system to get at it. This leaves them uncertain as to the management value of the reports they are generating. A couple of hospitals have attempted to adjust their own charges to costs using Medicare's ratio of costs to charges. This is not entirely satisfactory given errors in the way overhead costs are stepped down in departments. Surgical DRGs, for example, may be less costly than might appear if too many overhead costs were assigned to the OR.

Another problem with the reports is that the Medicare payments do not include the capital pass-throughs or indirect medical education. (Whether they even include any outlier payments is unclear.) This tends to make all DRGs appear to be losers.

3.5 CEO/CFO Criticisms of PPS

Hospital CEOs and CFOs had a number of positive and negative things to say about PPS. Their paraphrased quotes have been organized by topic area.

Update Factor

"The update factor is too politicized."

"The update ought to be tied to the increased cost of services and not a strictly political decision."

"The Federal government is turning PPS into a game with the zero update."

"No certainty in next year's PPS rates makes it very difficult to budget."

"PPS will be undermined by the extent to which decisions are being driven by the Federal deficit."

"Shouldn't limit update as a result of high profits because industry will need them for reinvestment in old plant and equipment later."

"No public policy on how much the country ought to spend on health care."

DRGs

"Reducing the DRG cost weights [through recalibration] unfair, as well as introducing uncertainty."

"HCFA was slow in raising the lens procedure (DRG 39) cost weight for new IOL costs."

"DRGs weights lag too much behind technical change."

"HCFA is manipulating the DRG cost weights to save money."

"High volume DRG cost weights went down [through recalibration] which looks suspicious."

"PPS has pigeonholed patients by diagnosis, accelerating discharges."

"DRGs won't last until 1995 because the future elderly will be too demanding of inpatient care to allow hospitals to stay within rates."

"DRGs OK but need fine tuning."

"It's not my job to whip physicians for HCFA."

Urban Rural Rate Differential

"Urban-rural rates unfair, allowing windfall payment to [a small urban] hospital."

"[A small urban] hospital is the same size and service mix yet gets the urban rate."

Wage Index

"I must pay the same wage rates in my rural area as in Burlington, but my wage index is much lower [.88 vs. 1.00]."

"My [rural] hospital competes with urban hospitals for high tech personnel and management, and my wage index is too low."

"There must be serious errors in the way that the wage index was re-estimated."

"We can't compete with other hospitals with such a low wage index."

Sole Community Hospitals

"SCH status is not that critical to my 50-bed hospital, but it would be to a smaller rural hospital."

"It is crucial that SCHs be treated differently."

"No incentives for SCHs to get efficient."

Outliers, etc.

"Why complicate PPS with a separate outlier payment? Why not just give each hospital a fixed amount for outliers up front?"

Capital Payment Proposal

"Capital passthrough elimination a real concern."

"Uncertain on capital costs."

"Crucial that SCHs be treated differently under HCFA's capital proposal."

"If Federal politicians decide to close my hospital even through State supports it, fine, but if they want to keep it open, give me the capital to renovate and become viable."

"Under new HCFA capital proposal, the wealthy teaching hospital which recently completed its renovation gets to keep its capital payment, but small, older hospitals lack capital to do the same."

"Hospitals are using capital funds to cover operating losses."

"Capital prospective payment is the most dangerous in the long run, leading to a long, slow death for rural hospitals."

"We are concerned about the short capital phase-in given our high [13%] capital cost ratio."

"Previous capital ought to be grandfathered."

"There seems to be lack of a national commitment to pay for old plant."

PROs/FIs

"FI wanted lump-sum settlement for outpatient services even before Medicare Cost Report was submitted."

"PROs a positive factor reducing inappropriate use."

"FI was four months late in issuing new Medicare Cost Reports which delays final settlement."

"The statewide PRO is crucial in altering MD behavior. Hospital staff lack authority and power because MDs can switch hospitals."

"Can't bill FI until MD signs off on patient's record which may be weeks if on vacation."

"Payment from FI slowed."

"The FI's definition of "skilled" nursing care too narrow."

"No longer getting blue sheets reporting beneficiary eligibility upon admission. Don't know what patient will be liable for."

General Criticisms

"When Blue Cross stops permitting cost-shifting, rural hospitals in Vermont will be in big trouble."

"Prospective payment has left some elderly without outpatient coverage."

"The Federal government has no control over MDs and is using the hospitals to get at them."

Positive Aspects of PPS

"PROs a positive factor on hospital use."

"PPS makes more sense than old cost-based system."

"Taking losses on some patients but still giving high quality."

"Statewide PRO crucial in altering MD behavior."

"PPS introduced need for cost control."

"Golden Age of '60s and '70s couldn't and shouldn't last."

"PPS forces hospitals to look closer at themselves."

4.0 PPS AND ALTERNATIVE HEALTH PLANS

There is no reported activity in northwest Vermont with respect to alternative health plans such as health maintenance or preferred provider organizations. Consequently, no interviews concentrated in this area.

5.0 MEDICAL PRACTICE PATTERNS UNDER PPS

Physicians in northernwest Vermont seem to have a conservative practice style in terms of admission rates and LOS. Most physicians have admission privileges in only one hospital, and little boundary competition seems evident due to the rural nature of the region. There is a strong overlay of competition between the two tertiary hosptials (Burlington and Hanover) at either end of the state, resulting in some rivalry for complex cases.

The confluence of technical trends, PRO pressures, and staff cognizance of unnecessary short stay surgery, has created a surge of outpatient surgery throughout the region, leading initially to big drops in admissions. Some drop in the (already short) LOS also occurred, though both trends have stabilized. The shift in admissions is not due to PPS incentives or to excessive hassling of admitting physicians. Broad trends in locus of care and PROs seem responsible. Shorter stays were observed initially, probably due to a widespread awareness of physicians of PPS incentives and some UR pressure, but certainly not due to aggressive administrative interventions into medical practice.

In spite of high (40-60%) Medicare dependency, hospitals appear not to have devoted much energy or dollars to altering practice patterns. Hospitals in the region appear to be better, or certainly no worse off, under PPS rates because of the conservative (for the region) styles of practice and favorable Blue Cross reimbursement policy. PPS revenue surpluses have provided these hospitals with the financial wherewithal to make needed investments in outpatient clinics and specialty services to facilitate favorable changes in admitting patterns while not alienating admitting physicians and patients. Nevertheless, PPS has lowered the resistance of these small hospitals to other volume "shocks" (like losing MDs) because they are paid only on admission now under PPS.

Some reductions in admission rates and LOS have also resulted from tougher PRO criteria, which have stiffened doctors' resistance to patient demands to use hospitals. Internal cost objectives are also met by PRO decisions, but little evidence exists that administrative actions have led to major changes in practice patterns. Physicians are explicitly left alone throughout the region, punitive sanctions for unnecessary utilization are unknown, and administrators applaud, not lament, their homogeneous practice styles which persist from the past. Further, no indications of ancillary or ICU/CCU utilization controls are seen. In some hospitals, physicians receive periodic DRG reports on LOS, payments, and charges, but little jawboning seems to occur even in these hospitals.

There is also no real evidence that specialization is occurring in this region. While physicians are occasionally aware of winner/loser DRGs, few attempts have been made to target admissions. Instead, many hospitals are aggressively diversifying their casemix by recruiting specialists, thereby limiting transfers to tertiary facilities and sealing off peripheral market areas. (Besides specialists, a few hospitals are establishing physicians in satellite areas.) Hospitals are making the necessary capital investments in facilities and equipment. Physician revenue guarantees have also been made, with the hospital

assuming the downside risk of keeping more of these severe cases without extra payment. There are indications that transfers or referrals of ICU/CCU cases to the tertiary facility are somewhat more difficult than in the past. Whether this is evidence of rural hospitals "dumping" or an attempt on the part of the tertiary hospital to "skim" cases is not clear, nor is there any data to support either allegation.

All but one hospital have exerted some effort in upcoding DRGs. The fact that one hospital is deliberately not tampering with coding is itself remarkable. Upcoding would seem to be moderate, certainly not intense, with some use of the special "grouper" software. Little indication exists that physician judgments regarding primary diagnosis are questioned. Doctors are largely ignorant of coding issues and in several instances profess total ignorance and no concern over DRG assignment. This general lack of physician awareness of DRG and PPS issues and incentives is fairly widespread. Some physicians, for example, do not realize outliers result in additional reimbursement nor do they know much about transfer reimbursement policies generally.

The residual problem with practice patterns in a PPS environment is the social admission and access to post-hospital subacute care. These access problems vary across northwest Vermont hospitals depending on financial wherewithal and peer pressure of admitting staff. In the post-discharge period the access problem seems two-fold. First, there is the cumulative effect on the beneficiary's financial ability to assume more hospital,* visiting nurse, or homemaker help which should cause more rapid spenddown to Medicaid eligibility. Second, there appears to be less access to subacute nonhospital care for the chronically unstable patients who have care needs that are frequently unjustifiable as HHA admissions because they require uncovered maintenance and prevention services.

There is definite evidence of favorable consequences of changed practice patterns in the region. Charting by physicians is much better, improving the capacity to deliver high quality care. Physicians are forced to document the course of pre-admission treatment, reason for admission, prescribed course of post-discharge care, and patient and family training pre-discharge. Charting must be more timely than in the past (as a precondition to billing), and the introspective analysis of the reason for admission may lead to better case management and more judicious admission decisions. Whether coding is now more or less consistent across hospitals is not clear, though it probably is due to consistently more attention being paid to it across hospitals.

The efficiency of capital use in medical practice is also improving. Use of non-hospital services is obviously increasing and the demise of the "wait and see" and social admission is occurring, reducing the use of high tech hospital capacity for patients who do not need it.

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*When a beneficiary drops to subacute-level 2 (ICF) care, the hospital has the right to bill the patient directly after notifying the patient of termination of Medicare benefits and waiting two days. This does occur though we have no data on frequency or portion of the balance billings collected by the hospital.

The use of outpatient surgery is also an important trend, in forcing MDs to use less capital-intensive modes of treatment. Hospitals are also aggressively pursuing more efficient accommodations through the use of swing beds, again increasing the efficiency of inpatient care services. Obviously, these trends beg the issue of how to control total system outlays for capital, both beds and equipment.

There is evidence of more homogeneity in medical practice, at least in terms of how the hospital is used by physicians. Limitations on "social" admissions and the use of the hospital as a subacute facility have definitely occurred. Northwest Vermont always provided less expensive care than in more urban places where peer awareness and pressure is less pronounced. The case study does not address the question whether there is more (or less) homogeneity with respect to use of office and subacute services. Now that physicians are making more use of such services, considerable variation could be expected.

There is generally more concern about case management. Hospitals are increasingly interested in vertical integration through HHA, SNF, swing bed and outpatient services, and some added attention is being paid by hospital staff (UR, discharge planning) to the efficient flow of services across the episode of illness. Physicians too appear to be made more sensitive to the economics of triaging by the necessity to use acute hospital services only for the episodes (or portions of episodes) where such care is needed.

There are suggestions that access to hospital and medical services has improved in limited ways. First, the rural hospitals are very concerned about needless referrals to the tertiary facilities in the region. Certain types of equipment have been purchased (particularly in cardiology) and more aggressive MD recruiting has been explicitly directed at the objective of keeping patients closer to home rather than referring them to hospitals 50-75 miles away. Secondly, some hospitals in this rural site have deliberately pursued satellite primary care facilities (and physician relocation guarantees). This is done to "shore-up" market area perimeters against encroachment by other hospitals. This has put primary care physicians in several rural locations where they otherwise might not have located, improving access to such services.

6.0 THE POST-HOSPITAL HEALTHCARE INDUSTRY UNDER PPS

6.1 Industry Structure

Hospitals in northwest Vermont generally serve a well-defined catchment area, as do the home health agencies. Each hospital works with one home health agency, except for the major teaching and referral center which refers patients to home care in communities in which they live. By contrast, a shortage of nursing home beds, particularly of skilled beds, means that hospitals must often go farther afield to obtain beds for patients.

At the present time, the nursing homes and home health agencies in the area are characterized by a relative absence of competition. State policies have contributed to a shortage of nursing home beds, resulting in waiting lists and high occupancy rates in most homes. Home health care is dominated by visiting nurse associations (VNA) practicing in the traditional manner of defined geographic areas. This seems on the verge of change, however, as two nurse registries may request a State Certificate of Need and Medicare certification. The state's largest VNA has responded in part by opening up a statewide practice. Specialized high-tech services are provided under contracts with single-purpose durable medical equipment and high-tech service companies.

Hospital arrangements with post-hospital care providers are generally informal, except in two instances where hospitals run nursing homes. The continued dominance of Visiting Nurse Associations in home health reflects hospitals' inertia in developing their own resources. Contractual arrangements are not common for actual services with two exceptions. Two hospitals contract with a VNA to provide discharge planning services while another contracts with a high-tech homecare provider for specialized services and equipment. In this case, all of the hospital's former patients using high-tech care are followed by the VNA.

Although large changes are not evident yet, one hospital plans to close its wholly-owned nursing home and enter a joint venture with a national chain to build a nursing home off the hospital campus. Another hospital is considering a nursing home, and one owns two nursing homes that are not Medicare-certified, although one provides skilled care. Yet another hospital has constructed a congregate living facility for the elderly, thus minimizing its days awaiting nursing home placement. When the congregate living facility was built, nursing home beds were freed up for more acute patients from the hospital.

Hospitals' use of subacute care beds or units is limited. One hospital has instituted a Cooperative Care Unit for pre- and post-acute care, staffed with a nurse only on the day shift. At night, patients are expected to be on their own, except in an emergency. The unit is used primarily for teaching prior to discharge, particularly to instruct patients and their families in IV therapy, parenteral feeding, ostomy care, etc. The unit costs the hospital only half that of an acute bed and the cost is borne by the hospital, not by the patient. The unit is to be expanded because it has proved very popular.

One of the rural hospitals is seeking swing-bed status for about 15 percent of its beds. Another rural hospital has also applied for swing beds to compensate for the nursing home bed shortage.

6.2 Hospital Admissions and Discharges

The national trend toward fewer admissions and earlier discharges is replicated in Northwestern Vermont. "Social" admissions, or patients admitted because they have no informal supports, or who need respite care, occur less often. Other marginal cases are, according to provider opinions, more frequently cared for at home.

The consensus is that patients are being discharged earlier and sicker than previously. They are receiving fewer rehabilitative services with shorter recuperative periods in the hospital. There is widespread belief that home health care, paid personal care, and informal supports are effectively substituting for hospital care in this regard. Nursing home care substitutes to a much lesser extent due to restrictions on third party coverage and the shortage of beds.

One hospital has addressed the problem of rural isolation by obtaining local funding to install Communicall systems in patients' homes. This allows the patient to make instant contact with the hospital, which has the medical record readily available. The hospital staff say they are convinced that the system keeps people at home and prevents unnecessary home health admissions.

6.3 Hospital Discharge Planning

Hospitals in northwestern Vermont for the most part follow the model of social service departments being responsible for discharge planning. Planners use the forum of meetings, rounds or grand rounds, plus record reviews shortly after the patient's admission to discuss post-hospital care needs, living situation, and so forth. One hospital planner states that rounds for this purpose were begun when PPS was implemented. In the largest hospital, the nursing department plays a stronger role in discharge planning, and a computerized nursing assessment form is scanned and flagged for discharge planning if certain indications are present. Some of the other hospitals also rely in part on the same indications, which usually are:

- strokes
- hip fractures
- living alone
- advanced age
- readmissions
- Medicare or Medicaid status.

All of the hospitals assess patient needs for post discharge-care, all provide information to patients and their families, and make placement recommendations. Once the desired placement is determined, the discharge planning staff actually arranges for care by locating nursing home beds and arranging home health care.

All of the hospitals appear to use multidisciplinary assessments to assist in planning for post-hospital care. In addition to nursing, hospitals will call in pharmacy, nutrition, and physical therapy if needed.

Three of the hospitals contract with the local visiting nurse associations to help provide discharge planning for home care. This eases the burden on the hospital staff as well as making a resource available that is knowledgeable about community services. Even hospitals without formal arrangements seem to rely on the home health nurses for help in post-hospital care planning.

Most of the hospitals contact the area Agency on Aging (AAA) when meals on wheels, transportation, visitors and the like are needed, and most of the hospitals maintain lists of homemakers and home health aides who work independently and who usually charge less than the home health agencies.

The hospitals in Vermont do not provide case management or formal service coordination. They do, however, try to keep track of certain patients through the HHA or by calling the AAA. One hospital respondent says the nursing staff sometimes calls the patients to see how they are progressing and to check on whether services are being received.

Although the hospitals usually try to initiate discharge planning close to admission, in fact it usually occurs only shortly before discharge. The physician appears to be the main reason for this; if he/she plays a major role in discharge planning, or insists on being the initiator, discharge planning and arranging for post-hospital care is often done at the last minute. In most hospitals the physician initiates; in two, the nursing staff or social services initiate it by identifying patients and recommending services. Overall the physician does not appear to play a major role in arranging for post-hospital care, particularly home care. The physician assigns the discharge date and signs the orders for care.

Major problems seen in this area of Vermont by discharge planners include the lack of nursing home beds, the lack of patient financial resources to pay for aftercare, and stringency of Medicare and Fiscal Intermediary interpretations. Some patients are hard to place because nursing homes do not want to accept them. These include those without money, those needing more intensive nursing care (tube feeding, respirator and ventilator patients), and patients with behavior problems. Discharge planners also cite various problems with Medicare, particularly Fiscal Intermediary stringency of interpretation of medical necessity. They claim that the only relatively certain conditions assuring SNF payment are tube feeding, respirator care patients, hip replacements or fractures, and stroke patients. These are also the most difficult to place in nursing homes.

6.4 Home Health Agencies

Home health care appears to be available in sufficient quantity in northwestern Vermont, implying that the VNAs do a good job of covering their territories. Short-term support care is sometimes unavailable or, if available, the patient often cannot pay for it.

Home health agencies generally perceive the hospital discharge planning activities as in need of strengthening, with an earlier activist role taken by non-physician staff or by physicians (if they are willing). The HHAs feel that hospitals are not yet able to provide quick response to discharge planning pressures that are created by shorter lengths of stay, less planning time, and more and different post-hospital care needs. They particularly cite physicians for failing to think ahead and for not notifying discharge planning that a patient is about to be discharged.

6.4.1 Adaptations

The home health agencies have all reportedly seen many changes in the past few years in both numbers and types of patients. There is a perception that the major changes took place in 1983 and 1984, with some stabilization in the past year. This, of course, would fit with PPS incentives creating fairly precipitous changes in hospital practices.

The HHAs see more hospital referrals, sicker patients, and larger caseloads. The major changes in the characteristics of the HHA caseloads are:

- Sicker patients requiring more high-tech care, such as total parenteral nutrition and IV therapies.
- More heavy care requirements such as daily or twice daily visits for dressing changes, drainage and wound care.
- Increased need for physical, speech, and occupational therapy.
- More complex problems, multiple problems, and thus more care needs and more difficult management of care.
- More terminal care (some have hospice programs, but most of the terminal care is provided as part of the home health service).
- Increased need for teaching in self-care.
- Short-term support care needs following hospitalization due to discharge before recuperation and regaining strength and mobility.

The agencies report that they have increased overall staffing to meet increased needs. Second, they have hired more therapists, and most significantly they are now hiring different kinds of nursing staff. Nurses with emergency room and intensive care unit experience are needed to care for the sicker patients. Some agencies say they no longer hire inexperienced nurses at all. Pay scales have increased to attract better qualified staff.

Some agencies believe there is a need for increased social worker activity in home health. They would use social workers both to help agency staff assess and deal with problem cases and to work with families. Although social work is considered a money loser for home health agencies, some feel that ultimately the care is improved and the costs average out.

Agencies are trying to diversify payer sources as a result of Medicare reimbursement problems and denials of services and to capture a share of the rapidly growing private market for care. The VNAs will be able to forestall competition only if they can show they serve private pay patients and those with other forms of insurance.

6.4.2 Medical and Administrative Problems

Home health agencies in our site visit are unanimous in citing problems of patients "falling through the cracks". HHAs cite:

- patients not admitted to hospital who need home care but are rarely referred by physicians, and thus go without;
- patients needing more short-term support services post-discharge, but there is no organized payment source;
- local funds once used to help pay for such care coming primarily from revenue sharing, which is being discontinued; and
- increased medical complexity (including multiple conditions needing care) and social problems encountered.

Fiscal Intermediary (FI) problems include interpretations of benefits and criteria as well as the "hassle factor" of claims denials and severe delays in payment that have occurred in the past year, reportedly at HCFA's insistence. Specific problems are:

- Deliberate slow-down in claims payment resulting in cash flow problems.
- Changing interpretations and overly stringent definitions.

Agency directors feel that medical necessity criteria are changing, that the daily care definition has been unfair* and the application of the homebound criteria have been too strict and have changed too often.

*The FI has admitted that it did limit this more than the HCFA manual required.

The impending move to a new fiscal intermediary has the agency directors concerned, primarily because they hear that start-up problems will cause delays in payment, and also because the new FI is an unknown quantity. They know that it takes time to figure out what an FI will pay for and to adjust to different criteria, definitions, and documentation requirements. In addition, the move to a small FI may result in claims review and processing failures, at least at the beginning.

6.5 Nursing Homes

The nursing home situation in Vermont is characterized by a shortage of beds. All of the facilities have waiting lists. Hospital-based nursing homes generally take referrals from their hospitals, but also from other hospitals. Both hospital-based and freestanding facilities report an extremely small number of Medicare patients and patient days. Indeed, one hospital owns two nursing homes that are not even certified for Medicare.

Reasons given for not obtaining Medicare certification are that the small amount of Medicare business does not compensate for all of the problems and paperwork involved. A major reason given for the very small percentages of Medicare patients (3 to 5 percent) is the strict level-of-care definitions required for coverage of care in a SNF. This situation, and the small proportion of Medicare patients in the facilities, has not changed since PPS.

Nursing homes have reportedly seen no appreciable changes in either numbers or case types since PPS began. One even has fewer Medicare days than before. However, others observe that skilled care patients appear to be sicker, and intermediate care patients need heavier care than before.

Nursing home administrators note a slight increase in tube-feed patients, and receive requests for IV patients. Some believe they are being asked to take more of these patients and fewer patients needing rehabilitation. The rehab patients are now being served in their homes by home health agencies, particularly when there are informal care givers. This situation has engendered some tension between hospitals and nursing homes over the types of patients that should be accepted by nursing homes. Some homes have not wanted to accept tube-feed or IV patients, preferring to give rehabilitation care instead.

Most common types of patients referred from hospitals continue to be hip fractures and hip replacements and strokes. There continue to be significant numbers of patients with Alzheimer's disease, dementia, and other behavior problems. These patients usually are paid for privately or by Medicaid, and for them, beds are often the hardest to find.

A commonly voiced perception is that Fiscal Intermediary (Medicare) level of care determinations have become more stringent for nursing home placements. This is cited as a major reason for the Medicare caseloads not growing in spite of earlier hospital discharges. An example is that of a patient with a decubitus ulcer; the patient must require skilled services on all three shifts to be approved for reimbursement.

Medicare does not play a significant role in nursing home care, a fact that has not changed with PPS. Stringency of claims review and eligibility determination appear to account for a lack of volume growth. Thus, with shorter hospital stays, waiting lists for nursing homes get longer and other payment sources must be sought.

Some interesting patterns of patient care have been observed in some sites. The configuration of facilities and, at times, levels of care and payment sources have changed patient flows. For example, one hospital built congregate housing, thus creating an outlet for light care patients in nursing homes. Hospitals are able to discharge patients waiting for nursing home placements, thus easing pressures on the hospital. Of course, nursing home caseloads have become sicker.

7.0 PPS PROGRAM OPERATIONS

7.1 The PRO

At the PRO for New Hampshire and Vermont, site team members met with the Executive Director and the Director of Data and Finance. Along with the third senior manager, the Director of Operations, this group comprises the most senior management team in the PRO industry, with 33 years of experience between them. This PRO was the original PSRO for New Hampshire. The PSRO of Vermont is now a subcontractor to the PRO, performing record reviews for Vermont, with the PRO performing all administrative functions.

The Director is on the board of AMPRA (the national PRO association) and visits a lot of other PROs. He feels that his is one of the most successful PROs, both in terms of meeting its contractual objectives and in positive working relationships with providers. This appears to be due in large part to the support the PRO has been able to generate from the state hospital association (through whom it worked in drawing up contracts with each hospital), the medical society and the specialty societies. A good example is the situation where there was inadequate representation of psychiatrists on the panel of PRO reviewing physicians. The PRO Director contacted the psychiatric association and told them other specialists would be reviewing their cases if more psychiatrists were not found to perform review, and the association was able to persuade some psychiatrists to participate.

This PRO emphasizes (and credits much of its success to) having on-site reviews performed at all hospitals, even the small, distant hospitals in northern Vermont. Requiring such small hospitals to xerox and send in medical records is felt to be a burden, and having the same person (nurse) on-site at a given hospital every week reportedly encourages open communication between providers and reviewers. Where many other states are moving away from on-site reviews, this PRO is adamant about continuing this effort. This seems to be greatly appreciated by the hospitals.

The PRO conducts a number of reviews that are not required by HCFA, and several for which HCFA does not pay. For example, PRO staff feel that even though HCFA no longer requires 100% prepayment review of all outpatient procedures performed in the hospital, this is an area where hospitals might try to take advantage of the system. The PRO will therefore continue this review. Another example is the review of all transfers to PPS-exempt units and hospitals. HCFA does not pay for these reviews, but again the PRO is concerned about hospitals manipulating the system and therefore plans to continue these reviews.

The PRO is very careful to explain to hospitals which reviews are mandated by HCFA and beyond the control of the PRO (like denial of planned readmissions), and which reviews are performed at the PRO's initiative and are amenable to input from providers. In this way, they do not "take the heat" for HCFA's decisions, and they allow interaction with the provider community (which in turn encourges acceptance and cooperation among providers).

PRO interactions with the FI are smooth, and except for some initial timing problems in receiving claims tapes from the FI, there are very few problems. If anything, the PRO program is simpler to administer because the FI performs virtually no utilization review at all of inpatient claims and gives blanket approval to all PRO determinations. There are no areas where both organizations might review a claim and have differing interpretations. The PRO is confined to inpatient review and the FI performs all outpatient and after care reviews. This separation of effort is advantageous in the opinion of both organizations' staffs.

The PRO has been reasonably successful in meeting its contract objectives. It has the best Super-PRO agreement rate in the country for quality of care objectives and an acceptable (average) agreement rate on utilization objectives. It uses nurses to perform all DRG validations because the administration feels coding involves a great deal of clinical discretion rather than being a mechanistic task. The agreement rate on DRG validation is not as high as the administration would like, but it still endorses the use of nurses for this task.

At the moment, there are a number of problems with HCFA's new denial of planned readmissions. Physicians and hospitals feel that this policy indicates ignorance of hospital operating room scheduling and patient flow, and that it removes an important area of physician case management and control. The PRO expects to continue to have problems in this area but also expects to see improvement and a decrease in this type of denial over time. This is a general pattern: many denials in the beginning of a new type of review with decreasing denials as the providers begin to understand and accept the new rules. The PRO interprets continuing high denial rates as a sign of poor communication with providers, essentially failure in its role. PRO staff feel that if they are meeting all their objectives and have low denial and sanction rates, they are successful.

The PRO does not see a great deal of patient dumping, mostly because there are no public hospitals in Vermont. Respondents agree that patients are probably being discharged earlier and in need of more services than in the past, and they feel that this is entirely appropriate. The Director is of the opinion that the shorter LOS is appropriate, but that the inability of the aftercare industry to meet the increased demand is what really threatens quality of care. In January, the Director asked the VNA of Vermont to contact him if there were any instances of patients being discharged who clearly should not have been. Since that time he has not had a single situation of this sort reported. The PRO is not aware of a new category of transitional, or subacute hospital care, but that may be because patients are billed for this care (if at all), and neither the FI nor the PRO receives a claim to review.

7.2 The Fiscal Intermediary

Inpatient claims processing is fairly straightforward. When complete and accurate data is obtained from the provider, the claim is entered into the system (this is performed 3 times per week) and paid (this is done once per week). Then a claims tape is generated for the

PRO. The FI conducts no inpatient utilization review. The claims processing "turn-around" time for all types of claims was consistently 6 days until this spring when HCFA directed the FI via the Regional Office to increase its inventory on hand to a minimum of 15 days. The slowdown was mandated in the form of the number of claims paid, not the dollar amounts. To lessen the burden on providers, the FI chose to concentrate on delaying OPD payments. The hospitals did not object because the FI could have delayed inpatient claims instead, which means a lot more money. Other providers appreciated the consideration, particularly home health agencies, who the FI staff felt could not withstand increased delays in payments. This slowdown was recently negated by a directive from the HCFA Administrator with instructions to speed up the claims processing workstream. The FI was pleased at this decision, as were providers.

There is no longer a Start of Care and Eligibility notice submitted when a provider begins to provide either inpatient or outpatient services. Now, the first communication with the FI occurs when the first claim is submitted, generally at the end of each calendar month. The provider does not know until this first claim is processed whether the patient is eligible for services and covered for the level of care provided. (The FI does try to phone providers when the claim is in processing if the level of care is in question.) This could mean that a patient is admitted to care early in the month, a claim is submitted at the end of the month, 15 days elapse (now shorter) for processing, and after a total of perhaps 45 days, the provider finally learns whether services will be reimbursed. This places providers at great risk. Hospitals have a similar problem in not knowing how many lifetime reserve days a patient has available, and aftercare providers have problems with level of care determinations.

Because the FI usually processes claim within 6 days, very few providers have felt the need to be on PIP. The elimination of PIP will only affect a handful of providers here, since nearly half of those who were on it are small and rural enough to continue to qualify. In fact, a few new providers are hoping to qualify now, spurred on by their sense that payment delays are going to continue.

All certifications and recertifications for home health services are reviewed by the FI, about 50% of all HH claims. This FI staff feels that for all this review activity, very little home care is actually denied and postpayment review of a smaller sample would be adequate. They will no longer be the FI for home care as of October, when the regional home health FI starts up. This FI will continue data processing however, with a telecommunications link to the regional FI.

The Vermont FI went to some effort to assist hospitals with the introduction of PPS. It provided information to hospitals on their base year calculations, their hospital-specific rate, and the payment they could expect for each DRG. Every year when DRGs are recalibrated and other policies change, it produces these reports for each hospital.

There appear to have been problems in the past with some of the definitions used in the utilization review of aftercare services. For example, the FI used to pay for a total of 6 weeks of intermittent care

with no extensions. After what seems to have been substantial discussion with the regional office and providers, the FI now pays for intermittent care without a real limit, provided the physician attests that there will be an end to the need for this care. This planned end of care date could be over one year, but as long as a physician continues to certify every 60 days that care is needed but will end, the claim is paid. If progress has leveled off and no end to care is in sight (maintenance care), the benefit ends.

Daily care is interpreted as 5-7 days per week, depending on whether the home health agency is open on weekends. Homebound care is defined as the patient being functionally, but not mentally, confined to the home. The number of times per month that a patient leaves home for any purpose is not used as a hard and fast rule; the FI states that each case is considered separately. SNF care determinations take into account the skill level required and the intensity of services. Ninety percent of SNF claims are now for fractured and replaced hips, with the rest mainly strokes and tube feedings. Non-technical denials are mainly for maintenance care.

There were also problems in the past with payment of OPD claims. The FI used to pay based on charges, and settled based on costs at the end of the year, which required recouping large sums from providers. HCFA was displeased with these large overpayments so now the FI uses an interim rate for payment, which gets closer and closer to true costs each year. This not only pleased providers who do not have to return large sums every year, it also improved the FI's CPEP scores due to reductions in overpayments.

The Vermont FI hears from aftercare providers that they are providing more intense services than in the past. However, this does not seem to be borne out in the claims (although the FI does not analyze patterns or trends). There is no increase in the number of services provided, as far as they can tell. It may be that the bulk of "new" aftercare patients are too intensive for home care but do not require skilled care, and therefore slip through the "cracks" in the benefit. Aftercare providers do not report seeing patients who should never have been discharged.

Finally, the FI states that claims are generally only returned once to providers for completion of data, and that when claims are reviewed for utilization or medical reasons, further data is requested via letters or phone calls, rather than sending the claim back. Although providers report repeated returns of claims, the FI describes the system as being smoother than that.

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